Employee Family & Medical Leave
Request Form - Military

City of Helena

Instructions for the Employee

- Complete the form and submit to HR. If you have questions call 447-8333 or 447-8404.
- You will be notified as to whether the leave is approved or not or if additional information is needed

EMPLOYEE INFORMATION

Employee Name: _____

Department: _____

TYPE OF LEAVE

I hereby request the following type of leave:

☐ **Leave to care for a family member who incurred an injury or illness in the line of military duty.**

Relationship to you: ☐ **spouse** ☐ **parent** ☐ **son or daughter** ☐ **next of kin**

Under this type of leave, eligible employees who are the spouse, son, daughter, parent, or next of kin of a covered service member are entitled to take up to 26 weeks of unpaid, job-protected leave during a 12-month period to care for the service member.

☐ **Leave for a qualifying exigency due to a family member's active military duty or call to duty.**

Under this type of leave, eligible employees are entitled to up to 12 weeks of unpaid, job protected leave during a 12-month period because of any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

AMOUNT OF LEAVE

(1) I request that the leave be granted for the following period of time:

Beginning on (date): _____ Ending on (date): _____

(2) I further request that the leave be granted for the following reduced or intermittent leave schedule:

_____

_____

(3) I would like to substitute the following paid leave time, if applicable, during my military family or medical leave:

☐ sick ☐ vacation ☐ other: _____

☐ Donated Sick leave – For illness only – See Personnel Policy – See Section 81-2a – Must meet criteria

EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and will subject me to discipline up to and including termination.

Signature: _____ Date: _____

MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE
FOR HR USE ONLY

Leave Approved: ☐Yes ☐No Beginning date: _____ Expected Return Date: _____

The following paid leave will be substituted: _____

Insurance premium to be paid as follows: _____

_____

Remarks: _____

_____

Signature of HR: _____Title:_____ Date: _____